Providence Hospital *and* Alaska Nurses' Association, Petitioner. Case 19–RC–12866

January 3, 1996

DECISION ON REVIEW AND ORDER

BY CHAIRMAN GOULD AND MEMBERS BROWNING, COHEN, AND TRUESDALE

On July 7, 1994, the Regional Director for Region 19 issued a Decision and Direction of Election finding that certain registered nurses whose unit status is in dispute should be included in the petitioned-for unit of all registered nurses. In accord with Section 102.67 of the National Labor Relations Board's Rules and Regulations, the Employer filed a timely request for review, and the Petitioner filed a brief opposing review. By Order dated September 21, 1994, the Board granted review solely with respect to the registered nurses whose supervisory status is in dispute. The Board denied review in all other respects. The Employer filed a brief on review.

On October 28, 1994, the Board heard oral argument in this case and *Ten Broeck Commons*, Case 3–RC–10166, in which the Board directed the parties to address the impact of the Supreme Court's recent decision in *NLRB v. Health Care & Retirement Corp*., 114 S.Ct. 1778 (1994), on the determination of supervisory status of charge nurses under Section 2(11) of the Act, and, in light of that decision, how the Board should interpret ''assign,'' ''responsibly to direct,'' ''routine,'' and ''independent judgment'' and how it should harmonize the provisions of Section 2(11) and (12). The parties in both cases as well a number of amici curiae[1] filed preargument briefs and/or participated in oral argument.

The Employer operates a 341-bed acute care hospital in Anchorage, Alaska, and has approximately 1600 employees, including about 700 registered nurses (RNs). The Employer's RNs are concentrated in six hospital centers, which provide traditional RN medical care. At issue is the status of RN charge nurses in four centers: medical, surgical, and oncology care; neuromuscular/skeletal rehabilitation care; emergency services; and women's and children's care. The Employer did not request review of the Regional Director's finding that the RN charge nurses in the cardiovascular and critical care center and in the surgical services department are not statutory supervisors.

Also at issue is the supervisory status of RNs who serve as home health care team leaders, home health care team leader assistants, on-call lead home health care RNs, lead outpatient/neurological rehabilitation RN, and employee health staff nurse.[2] The Employer has not requested review of the Regional Director's finding that the emergency department psychiatric nurse consultant supervisor and the endoscopy coordinator are not statutory supervisors.

The Petitioner would include the disputed RNs in the petitioned-for unit of all RNs. In its request for review and its brief on review, the Employer contends that the disputed RNs are all statutory supervisors because they use independent judgment in both assigning and responsibly directing employees.

Having carefully reviewed the record, the parties' briefs, the amici briefs, and the oral argument, the Board has decided to affirm the Regional Director's decision. In so doing, and as discussed in detail below, we apply the Board's traditional analysis for determining the supervisory status of employees in other occupations and conclude that the employees at issue do not exercise the ''independent judgment'' essential to a finding of supervisory status.

I. FACTS

A. *Charge Nurses*

The disputed RN charge nurses work in two major hospital divisions: care centers and ambulatory care centers, each headed by an assistant administrator. The care centers division includes the medical, surgical, and oncology center; the neuromuscular/skeletal center; and the women's and children's services center. The ambulatory care division includes the emergency services center. All the centers have directors, who were the principal witnesses for the Employer. All the separate centers except emergency services have multiple departments with RN charge nurses. All but one of the separate centers and the separate departments within the centers have supervisory RNs who were stipulated to be statutory supervisors.

Although the Hospital has a job description for the position of RN charge nurse, the Hospital's practices vary from care center to care center and sometimes within the separate departments of each care center, particularly with respect to determining which RNs may serve as charge nurses and who will serve in that position during any given shift.

No disputed RN serves as a permanent charge nurse; rather a varying number of RNs at each center rotate in the position. Moreover, in most departments a staff RN does not serve as charge nurse when a supervisory RN is present and on duty in that capacity. Generally,

[1] The Chamber of Commerce of the United States; New Jersey Hospital Association; American Federation of Labor and Congress of Industrial Organizations, et al.; Labor Policy Association; American Nurses' Association; Council on Labor Law Equality; Service Employees International Union, AFL–CIO, CLC; American Health Care Association; Local 1199 National Health and Human Service Employees Union; American Hospital Association; Union of American Physicians and Dentists; and the General Counsel of the National Labor Relations Board.

[2] The Board denied review of the Employer's contention that this position should be excluded on other grounds.

when the supervisory RN is present, the supervisory RN serves as charge nurse. On occasion, however, a supervisory RN will come to work in street clothes, rather than uniform, for administrative duties (not otherwise explained in the record); on such occasions the supervisor is not directly involved in overseeing patient care. When the supervisory RN is on administrative duty or on leave, a staff RN will serve as charge nurse. Similarly, on shifts when no supervisory charge nurse is present, a staff nurse serves as RN charge nurse. Despite these differences, charge nurses throughout the Hospital have essentially the same responsibilities.

1. Medical, surgical, and oncology care center

This care center has roughly 100 RNs in 5 different departments: surgical, medical oncology, cancer therapy, pain, and enterostomal. The center utilizes RN charge nurses in two traditional inpatient departments, referred to as floors: medical oncology and surgical. Not all RNs rotate as RN charge nurses. Instead, the center identifies a core number of RNs to designate as RN charge nurses based on clinical competence and leadership abilities. The charge nurse position is posted for bidding in this center.

On the medical oncology floor, the Hospital has an RN supervisor present on each of the three shifts. About 25 percent of the RNs on that floor rotate as RN charge nurses. The RN supervisors, when not on administrative time or otherwise absent, on vacation, or on days off, fulfill the charge nurse role. Because RNs serve as RN charge nurses only when the RN supervisor is not filling that position, the RNs rotate as charge nurses less frequently than they would if no supervisor were present. The director of the medical, surgical, and oncology center estimated that on the medical oncology floor some RNs rotate as RN charge nurses 20 percent of their time and that others may do so 50 percent of their time.

On the surgical floor, about the same 25 percent of RNs have been designated for RN charge nurse duty. That floor, however, has an RN supervisor only on the day shift. On the evening and night shifts, the RNs who have been designated as able to be RN charge nurses serve in that capacity from 60 to 75 percent of their time. Although only certain RNs are designated as able to serve as charge nurses, an RN, who was not so designated, testified that, on an occasion when the assigned charge nurse failed to appear for work, the other RNs asked her to serve as charge nurse, but she refused.

The RN charge nurses' responsibilities are nearly the same for both the medical oncology floor and the surgical floor.[3] The RN who serves as RN charge nurse is set by the monthly staffing schedule prepared by the center director or the supervisor; RN charge nurses do not have any input into preparing the monthly schedules. Nonetheless, charge nurses have swapped being the charge nurse with other RNs; they do not need permission, but merely record or report the fact. RN charge nurses generally do not carry a patient load, but may do so on a reduced basis on the night shift when things are less busy or when the center is short staffed or otherwise exceptionally busy. RN charge nurses are generally responsible for coordinating patient care within the areas of their responsibilities. Specifically, they are responsible for preparing the end-of-shift reports. Those reports are used, among other things, for reporting any deficiencies in performance that management needs to know about. Staff RNs, however, may also make entries on such reports.

More specifically, the director of the center testified that the RN charge nurse, at the start of a shift, would assess the patients' needs to determine their stability and lability and whether a patient requires care by an RN, an LPN, or an aide. For example, if the charge nurse determines that a patient needs one-to-one care, the charge nurse will determine the type of care provided. If the problem is behavioral, such as a patient trying to crawl out of bed, the charge nurse may determine that an aide simply needs to be with the patient, but if it is because the patient is at risk of life, the charge nurse would make a different determination.

The center director also testified in general that the RN charge nurses ''have the responsibility for assessing the patient's [sic] needs based on their conditions, or acuities, as well as the individual components of those needs, such as the predictability and determining an appropriate staffing level and assignment based on the staff's capabilities and levels.'' The director, however, also testified that ''the RN that is not a charge nurse is responsible for assessment of patients' conditions and needs.'' In addition, an RN charge nurse in the surgical unit testified that she did not tell RNs what to do: ''They are professionals, and they know their jobs.'' Rather, the charge nurse makes assignments with input from the staff RNs. Staff RNs have swapped assignments without approval of, but with notice to, the charge nurse.

The charge nurse, when two aides are present,[4] decides the scope of the aides' workloads, although typically the units have already determined that an aide may cover half the floor or a certain number of patients. Staff RNs, however, tell the aides what tasks to perform, such as, ''I want you to change this dressing.''

RN charge nurses are responsible for monitoring whether scheduled employees have arrived and for following up by trying to locate any absent employee. If

[3] There are, however, a different number of patient care technicians (nurses aides) and licensed practical nurses on each floor.

[4] On the surgical floor, only one aide is present during a shift.

unsuccessful, the charge nurse decides if a replacement is needed and, if so, contacts the shift coordinator.[5] In addition, the charge nurse is responsible for determining the need for the scheduled staff. If the shift is understaffed or overstaffed,[6] the charge nurse notifies the shift coordinator that extra help is needed or that extra help is present. The coordinator may then send an RN from another part of the Hospital to the unit or may request the loan of an RN from the unit. If the shift coordinator has been unable to find an in-house replacement, the charge nurse may attempt to call in an off-duty RN. There is, however, no evidence that the charge nurse may require an RN to report to work. If RNs are not needed elsewhere in the Hospital and the shift remains overstaffed, the charge nurse may send the employees home, sometimes on a call-in basis. An RN charge nurse on the surgical floor, however, testified that the shift coordinator has denied permission for the charge nurse to send an RN home early even though the RN was not needed elsewhere in the Hospital. That charge nurse also testified that she is expected to check with the shift coordinator to approve bringing in extra staff.

At the end of the shift, the charge nurse is responsible for monitoring patient acuities and determining their needs and also for determining the staffing needs for the next shift; the charge nurse makes whatever adjustment is necessary. If the patient load warrants, the charge nurse may check with the shift coordinator to see if in-house help is available. If no help is available, the charge nurse can offer employees overtime. An RN charge nurse in surgery, however, explained that charge nurses do not authorize overtime; employees who ''stay'' over just write on the shift report how long they worked. There is no evidence that a charge nurse may require overtime.

The RN charge nurse also monitors other employees' skills and performance. If, for example, a staff member is displaying improper methods of communication with another department, the charge nurse is responsible for observing it and, if severe, making an intervention. A charge nurse may also intervene in disputes between staff members. In one instance, one staff member was told to do something by another and objected; the charge nurse was called to make a decision. In another example, a charge nurse was called on to settle a dispute between two RNs over equitability of assignments—one RN had six and the other four patients. The charge nurse decided that the assignments would remain as they were.

[5] Shift coordinators have Hospital-wide responsibilities and are within the nurse resource office management structure.

[6] There was generalized testimony that there are guidelines to maintain one RN for every five or six patients during the evening shift and one RN for every seven or eight patients on the night shift. There is no evidence on how the policy was determined or to what extent the guidelines are rigorously followed.

If there are immediate problems, a charge nurse might report to the shift coordinator. Typically, however, the reporting mechanism is through the end-of-shift report. Staff RNs may also make entries on that report. According to the director, if a staff RN observes an acute problem or a life threatening situation, the RN would be expected to make an immediate intervention and for lesser situations would be expected to make a report. The director testified: ''Based on state practices, I don't think any RN could ignore or abandon an acute situation.'' A staff RN testified that she has reported deficiencies of other RNs directly to the supervisor. The RN also testified that she reported that a charge nurse was having difficulty in performing as a charge nurse and suggested that the charge nurse no longer serve in that capacity; the suggestion was followed. An RN charge nurse testified that she has never noted performance deficiencies as a charge nurse, but on one occasion, as a staff RN, she asked another RN not to leave dry IVs.

Charge nurses have been asked by management for their evaluations of staff members. Other staff members, however, give input into evaluations. According to the center's director, the charge nurses do not have a greater role in evaluating employee performance but look at things from a different perspective—from a more global perspective, such as the adequacy of interpersonal skills and whether teamwork and collegiality are displayed. A charge nurse in the surgical unit testified that the Hospital utilizes a peer review process in which each RN reviews the RN she ''follows.'' Also, that charge nurse testified that she participated in an interviewing team, but as an RN, not as a charge nurse.

2. Emergency services center

This care center has three different units of which only the emergency department has RNs. That department has 48 RNs, 15 of whom serve as RN charge nurses. Of the 15 charge nurses, 5 serve in that capacity about 90 percent of their time. The others apparently spend from 25 to 75 percent of their time in that capacity. Charge nurses are used on all shifts, apparently even when the RN supervisor is present; about half the time they are the highest authority present in the unit. Charge nurses perform clinical duties only when necessary and do not take a regular patient load; they, however, spend 10 to 15 percent of their time providing patient care. RNs must apply to become charge nurses and are interviewed by the RN supervisors and the director. There is no formal process for training RNs to become charge nurses.

The department supervisors develop the monthly schedules. Although the emergency department is, in the words of the center's director, ''organized chaos,'' the department can reliably predict from month to

month and year to year the number and type of patients—from gunshot wounds to myocardial infarctions. From hour to hour, however, predictions cannot reliably be made.

If someone is absent, the charge nurse attempts to replace that person. The charge nurse may also decide that additional staff is necessary when multiple patients arrive from a car or plane accident, an event that happens once a month. In these circumstances, the charge nurse reviews the staff schedule and sees who might be available to call in to work, but has no authority to require someone to come to work. The charge nurse may also request an employee to stay overtime, which happens on at least one shift every day. The charge nurse does not need to check with anyone to authorize such overtime, but does record the matter on the end-of-shift report. Before authorizing overtime, however, the charge nurse checks to see if the shift coordinator can send staff from another part of the Hospital. Most often the shift coordinator can find extra help, especially for a short time, which is what the unit usually needs. The charge nurse may also call an employee in early, but that happens less frequently. An RN testified that when acting as a charge nurse he had to obtain permission from the coordinator because he would have to go to her first. Only rarely does an off-duty RN need to be called from home. If the department is not busy, charge nurses may ask for volunteers to take unpaid leave, but they do not have the authority to send someone home.

The night shift charge nurse completes a patient assignment form for the next day, taking into account the RNs' skill levels and the patients' acuity. Charge nurses, however, generally make such assignments on a rotational basis, with the exception of the pelvic examination rooms in which gender is taken into account. Charge nurses may also change an employee's assignment to a different patient. They authorize breaks, including lunchtimes, but breaks are given on a rotational basis, with the first in given the first break.

Emergency department charge nurses prepare an end-of-shift report. The report, among other things, might address basic equipment failures or a patient's being upset with treatment or a staff member. The charge nurse also prepares a staffing form indicating the hours employees have worked or been absent.

Charge nurses monitor both the clerks' and the RNs' performance and respond to any problem. As an example, the director testified that when an RN made what a member of the patient's family thought was an inappropriate remark, the charge nurse immediately followed up by contacting the family member to try to resolve the issue. Another instance involved a miscommunication between the department and the lab; the charge nurse wrote a report of the incident for the emergency department director to follow up with the lab director. Charge nurses, however, do not formally counsel RNs; if there is a problem, the charge nurse tells the RN, ''This is the procedure at this Hospital.'' Also, the director testified that staff RNs might intervene and are expected to do so if they observe unsafe procedures. Charge nurses may, however, submit reports to either the supervisor or the director concerning any problems in the quality of care given by an RN, and such reports can become part of the RN's personnel file. A charge nurse testified that he has ''disciplined'' another RN but merely as a fellow professional by taking the RN aside and expressing concerns.

Supervisors solicit input for evaluations from charge nurses and to a lesser extent from RNs. Charge nurses, however, do not provide input into the formal written evaluations. A charge nurse, the supervisor, and the director serve as the team that interviews applicants.

3. Neuromuscular/skeletal center

The neuromuscular/skeletal center has eight or nine departments. RN charge nurses are in the orthopedic/neurology and the rehabilitation departments.[7] In the orthopedic/neurology unit, RN supervisors are assigned to all three shifts—days, evenings, and nights. When the supervisors are working, they serve as charge nurses; they are present about 95 percent of the time. About 5 of the 30–35 RNs serve as charge nurses, but only when the supervisor is absent. About once every 4–6 weeks a supervisor may be absent for part of the day.

By contrast, the rehabilitation department does not have an RN supervisory position. There are 18 RNs in that unit, all of whom are parttime, and all of whom serve as charge nurses. Only six to eight, however, regularly serve as RN charge nurses, and they do so nearly every day; the others serve only when the primary charge nurses are absent, about once every 3, 4, or 5 weeks.

Despite the differences in frequency of staff RNs serving as charge nurses, the duties of the RN charge nurses in both units are for the most part the same. They are paid a 5-percent differential for the hours they work as charge nurses. Charge nurses in both units provide hands-on patient care, but with a reduced patient load.

The charge nurses schedule, approve, and disapprove breaks.[8] The charge nurses communicate with management regarding patient census and acuity; they communicate with the shift coordinator to assure there is adequate staffing. A charge nurse testified that she

[7] In addition, the neuro outpatient rehabilitation department in this center employs one RN serving as a leadperson, whose supervisory status is also in dispute. This position is discussed below in the sections on other supervisory issues.

[8] A charge nurse testified that charge nurses, when they take breaks, inform staff RNs, so the charge nurses' patients can be covered.

contacted the shift coordinator whenever she needed an RN, a licensed practical nurse, or an aide. If the charge nurses cannot get adequate staffing through the shift coordinator, they have the authority to call in other staff and to authorize overtime by calling in staff early or holding staff over. In both units, charge nurses make daily work assignments. The record, however, gives few details. In the rehabilitation center, the charge nurses' assignments must take into account the nursing teams used in that unit and the need to communicate with charge therapists. In that unit, they also coordinate the patient and family conferences.

The RN charge nurses in both units have the responsibility to assure that the Hospital's standards of care are being carried out, to intervene the moment they discover a problem, and to suggest solutions. For example, a charge nurse may tell staff RNs they are doing something wrong, give direction on how to do something differently, change patient assignments, or decide that a physician needs to be called. A staff RN may, however, make similar interventions. The director recognized that all RNs have the responsibility to report quality care concerns but explained that the charge nurse ''has the authority to actively do something about that.''

The charge nurses give input to the manager about RNs with performance problems and have been involved in retraining plans. According to the center's director, staff RNs are involved in identifying skill deficits, but the charge nurse is involved in developing corrective educational plans. Charge nurses as well as staff RNs fill out peer review forms that rate RNs' work from excellent to poor.

The charge nurse is responsible for the 24-hour shift report.[9] The report describes the patient census, the RNs who worked, any problems that occurred, and how they were handled. The reports may make recommendations for further education, for program changes, or for system changes. They are used to report anything that needs to be followed up on by management.

4. Women's and children's services center

This care center has three departments: pediatrics, maternity, and newborn intensive care (neonatal). In maternity, there are 9 RN supervisors, 60 staff RNs, 14 RN charge nurses, 6 health unit clerks, and 2 LPNs; in pediatrics there are 16 RNs, 12 RN charge nurses,[10] 1 RN supervisor, 4 LPNs, and 2 health unit clerks; in neonatal there are 60 staff RNs, 6 RN charge nurses, 4 RN supervisors, no LPNs, and 6 health unit clerks. RNs become charge nurses after an interview, evaluation, and orientation process.[11]

In the maternity and neonatal units RN charge nurses spend about a third of their time as charge nurses and the rest as staff RNs. Supervisors and charge nurses generally work 12-hour shifts, 3 days a week. In maternity, four supervisors work in the labor and delivery subunit, and five in newborn; supervisors are present on weekends.

The duties of charge nurses in each department are essentially the same. All receive a 5-percent pay differential while serving as a charge nurse. Charge nurses provide direct clinical care when called on to do so, but do not take a full patient load unless dictated by the patient census. They do not schedule the days a nurse will work or be off. They do, however, make daily work assignments taking into consideration the patients' needs, the RNs' skills, and which RNs have previously been assigned to which patients. A pediatrics charge nurse, however, described daily assignments as a ''collaborative effort of everyone that's there.'' In addition, RNs on their own may trade patients.

Charge nurses verify attendance. If an RN is absent, the charge nurse is responsible for finding a replacement. The charge nurse asks the charge nurses in the other units in the center if they have staff available. If not, the charge nurse contacts the shift coordinator for a replacement. If those two steps are not fruitful, the charge nurse goes through a list of staff available to come in for partial shifts. Obtaining a replacement occurs, according to the director, about three-quarters of the time. Charge nurses also may need to find additional or replacement RNs for the next shift. They have the authority to authorize overtime, which according to the director occurs at least a couple of times a week. There is no evidence that they can compel overtime. Also, a non-charge RN testified that she had worked overtime without checking with the charge nurse. If there is a low patient census, charge nurses may send employees home, which happens about half the time. The charge nurse, however, first checks with the shift coordinator to see if an RN is needed to float elsewhere in the Hospital. A charge nurse in the newborn intensive care unit testified that before calling someone in, she has to check with the shift coordinator and that, if someone is not available in-house, the shift coordinator will tell the charge nurse to find someone.

In selecting which RNs to send home or float, a pediatrics charge nurse testified that charge nurses use logbooks to make this determination. Whoever has accumulated the least number of floats or had the least

[9] The report has also been referred to as the end-of-shift report. According to the director, the report is available for staff RNs to read but not to make entries.

[10] The policy in the pediatrics unit is to have all RNs rotate as charge nurses; however, four RNs are new and have not yet been involved in rotating as charge nurses.

[11] This has not been the practice in pediatrics, which has been recently added to the center.

time off is selected. According to the charge nurse, she, herself, has taken time off as a result.

Charge nurses determine breaktimes, but the expectation is that staff RNs let the charge nurse know when it would be a good time for them to break. According to the director, charge nurses tell employees about half the time that their requested breaks are at an inappropriate time, usually because there is no one available to cover the RN's patients or the RN is needed to help with other patients.

RN charge nurses monitor adherence to policy procedures, patient care, customer relations, and incidents out of the norm. They are expected to address any problem immediately. Serious problems are reported in an incident report form and entered into the 24-hour report. Very serious problems must be directly reported to the director or the clinical manager. Charge nurses also respond to problems. For example, if there is a disagreement between a patient and an RN over how care should be delivered or a personality conflict, the charge nurse would be expected to determine what the issue really involved, and, if necessary, reassign the RN. Another specific example involved an RN giving the wrong medicine; the charge nurse issued an incident report, which the director used in the disciplinary process. The director also testified that, if a staff RN observed a serious problem in the care given by another RN, the staff RN would be expected and required to submit a written report of the incident. A non-charge nurse testified that she has reported such deficiencies: ''As nurses we learn right off the bat in nursing school that you are first and foremost a patient advocate.''

Charge nurses also have general, usually oral, input into the evaluation process for RNs, LPNs, and unit clerks. Staff RNs, however, also give input into the evaluation of RN charge nurses. Charge nurses are responsible for the accuracy of the 24-hour report and the staffing sheet. Staff RNs serve as mentors or preceptors for orienting new RNs into the unit.

B. *Other Supervisory Issues*

1. Home health care team leaders and team leader assistants

The home health care department has two units with contested RNs. Skilled services provides the ''high tech'' end of home health care including nursing care, physical therapy, and speech therapy for people who are generally homebound. This unit has five nursing teams: three adult teams, a pediatric team, and a perinatal team. The unit has 20–25 RNs of whom 9 are leaders or leader assistants. Each team has a team leader. All adult teams have a team leader assistant. Whether pediatric or perinatal teams have a leader assistant varies; sometimes the department does not immediately replace an assistant who has resigned. The team leader assistant fills in when the team leader is not there.

The team leader generally is responsible for the extensive paperwork requirements in home health. The leader may decide to do the paperwork or may assign the task to someone else. Team leaders generally have a reduced patient load. Team leaders are responsible for a patient's overall case management, reviewing such matters as referrals, coordination with other disciplines, documentation for insurance, documentation for physicians, and communication with physicians.

Team leaders make patient assignments based on the needs of a patient, the skills of the RN, and the requirement that assignments must be equitably distributed among the staff. It is the responsibility of the team leader to see that each team RN averages five billable visits a day. The team leader also takes into account the geographical area in which the nurse has current patients and assigns new patients in the same area. RNs, however, have input into assignments. Generally, team leaders assign patients to staff RNs, and staff RNs schedule when they see the patients. Team leaders also shuffle staff RNs from one team to another ''all the time.'' A team leader makes adjustments in initial assignments on a daily basis for such things as changes in a patient's condition, a patient's availability, or a staff RN's request. Staff RNs, however, change patient assignments among themselves, provided only that they leave a message of the change; they do not need advance permission.

In making assignments, the team leader informs the RN what needs to be done and gives the RN the necessary supplies, such as a dressing change. Staff RNs, however, provide an outline of what needs to be done for the RN who will make the next visit. Team leaders, after receiving the supervisor's[12] permission, may call in supplemental staff—RNs who are willing to work part-time in the program.

An RN, when starting in the department, receives initial orientation and training in the office. The RN then works with the team leader to learn details on how to perform the visits in a reasonable time and how to fill out the paperwork. If a team leader notices that an RN is deficient or rusty in regard to a particular procedure, the team leader is expected to suggest joint visits with another RN skilled in that procedure, or perhaps, spending some time in the outpatient therapy center for additional training. The team leader may follow through by assigning the RN to patients requiring that procedure.

RNs fill out patient status reports describing the patients' problems, conditions, and treatments, which a leader reviews. One example was given in which a team leader's review of an RN's report indicated that

[12] At the time of the hearing, the assistant director filled that position.

the RN had not asked some of the essential questions for the intervention involved. The leader talked to the department director and proposed a retraining program for that procedure, which the director approved.

In reporting poor performance of a staff RN, a team leader does not give recommendations to management. Rather, the team leader discusses possible courses of action, but those are not always followed. According to the department director, team leaders do not have ''authority to discipline independently'' but instead provide information to the director, who chooses whether to go forward with discipline. A team leader testified that she never disciplined an employee except when she was filling in for the supervisor, and even then it was only at the direction of the director. The director also testified that it is the ethical obligation of a staff RN to report any noticed skill deficiencies of other RNs to the supervisor. Staff RNs, however, are not expected to suggest a plan of corrective action.

Because the department supervisor does not regularly observe the RNs' clinical work, the team leaders are in a better position to assess the skills of the team RNs and are consulted during evaluations. The supervisor gets the evaluation form, sits down with the team leader, and the two of them go through the form item by item. According to a team leader, however, it is the supervisor who does the formal evaluations. In addition, staff RNs are encouraged to provide information about other employees' performance as part of the peer review function and are expected to report inadequate performances of other RNs. Team leaders have made hiring recommendations, but so have staff RNs.

2. Home health care on-call leads

The personal care and support unit in the home health care department provides more general home care, such as assistance with bathing, grooming, shopping, cooking, homemaker services, and other ''low-tech'' care. Because of its varied nature, the work may be needed at any time of the day. The unit employs health aides; it has no RNs who provide hands-on care. The department has two on-call leads, both RNs, who ''fill-in'' for the supervisor during the hours the office is closed. The on-call leads rotate a week on and a week off. The on-duty lead is available by beeper or by phone to respond to messages from the answering service. Only rarely, about once every 2 years, are the leads called on to perform actual home care.

The approximately 40 health care aides receive their assignments during the day from the schedulers in the office. The on-call leads make assignments when a regularly assigned aide is absent. In the winter, when there is a lot of snow and it is the flu season, this happens daily; during other seasons there are weeks when it does not happen every night. Frequently, a patient calls up and reports that the aide has not appeared as scheduled. The on-call lead attempts to find out the cause of the delay and may have to find a fill-in employee.

When a fill-in employee is needed, the on-call lead attempts to match one of the 10–15 available aides who work during off hours to the needs of the client. The on-call lead refers to a ''book'' containing information about the needs of the clients and the particular qualifications of the aides. There are about 20 different skills requiring special qualification. For example, to operate a particular kind of sling lift, an aide must have received qualification through instruction from an RN. The on-call lead also is expected to match more intangible things such as the personalities of the aides, because the care is in many instances of the most intimate nature.

At times, the on-call lead will have to ''walk'' an aide through a problem; one example was explaining how to contact a client when the outside security door to the client's apartment is locked. The lead also fields patients' complaints by attempting to ''smooth ruffled feathers'' or to otherwise resolve the perceived problem. If an aide is unwilling to make an assigned patient visit, the on-call lead will instruct the aide to complete the work assignment. In one instance, an aide refused to carry out an assignment, the on-call lead had to find a replacement, and the lead reported the incident to the supervisor with a recommendation that the aide be disciplined.

On-call leads provide the supervisor with essential information on aides' performance on a weekly basis, sometimes orally and sometimes in writing. The supervisor uses this information in evaluating the aides for reliability, attendance, and the ability to perform the clinical functions of the job. Leads may also report particular problems or offenses to the supervisor. The leads usually, however, do not recommend any particular action such as a warning letter, suspension, or discharge, although they may state the event was a level ''A'' offense. The department has a progressive disciplinary policy; thus, any resultant discipline depends on the number of prior infractions as well as the severity of the offense.

3. Employee health staff nurse

The employee health staff nurse performs a variety of functions regarding the Hospital's employees who have been injured on the job. Those employees, during the course of their rehabilitation, are assigned such hospital work as they are capable of performing. The Employer contends that the employee health staff nurse acts as a statutory supervisor for the employees in that situation.[13]

[13] The Employer did not request review of the Regional Director's finding that the employee health staff nurse is not a confidential em-

Continued

The on-the-job recovery program helps employees who have been injured on the job to return gradually to work. Employees who have been released by their doctors to return to limited duties contact employee health, which is responsible for placing the employees in limited-duty jobs. The employee health specialist or, in her absence, the employee health staff nurse, is responsible for seeing that the employees do the work, such as reporting on time and completing the assigned tasks.

The employee health specialist, who was stipulated to be excluded from the unit, and the employee health staff nurse do no hands-on nursing care. Generally, they are involved with workers' compensation; the Americans with Disabilities Act; counseling employees encountering difficulty handling their jobs, such as lifting patients; seeing that employees follow universal precautions, such as wearing protective masks and gloves; checking out reports of employee substance abuse; and overseeing the on-the-job recovery program. The employee health specialist has primary responsibility in overseeing these programs. The health staff nurse performs the oversight function when the specialist is away from work during vacations, for various meetings, illness, etc. According to the director, this happens several times a month.

The specialist and, in her absence, the staff nurse, are responsible for signing timecards. They are also involved in setting employees' pay, which is determined by a formula which combines the pay rate of the temporary position and the workers' compensation payments; the personnel department is also involved. The staff nurse makes those decisions for the employees with whom she is directly working.

The specialist and staff nurse assign the employees in the program to particular jobs within the Hospital based on their assessments of the employees' capabilities. Although they make the initial assignments, the unit supervisors make day-to-day assignments to particular tasks. This is, however, a collaborative effort. The employee health specialist and staff nurse make sure that unit supervisors' assignments and directions do not exceed the limited-duty boundaries in terms of both tasks given and time performing the tasks. They may complete evaluations of employees involved in the program, but those evaluations are primarily geared toward determining what limited functions the employee is capable of performing.

They also may ''discipline'' employees in the on-the-job recovery program if employees decide not to do the work or refuse to participate in the program. The only record example, however, was giving oral counseling to an employee.

4. Lead: neuro outpatient rehabilitation center

This center services patients who require rehabilitative therapy beyond an inpatient stay and who receive a variety of therapies over a course of months. The department includes physical, occupational, and speech therapy subunits. Each subunit has a supervisor. There is one certified rehabilitation RN, the only RN in the department, who serves as the ''lead'' person for the unit. The lead spends about 25 percent of her time providing direct patient care as an RN. The lead coordinates the therapy departments and referrals to other providers, such as psychology and community services. The lead interfaces with physicians, obtains orders, gives progress reports, and serves as a quality improvement coordinator. The lead also participates in the decision of which staff member will take patients out in the community, for what therapeutic purpose, and when.

A physician determines the necessary services; the lead assigns patients to particular therapists. In assigning patients, the lead takes into account the particular skills and availability of the therapist. For example, if a patient is referred for disabled driver's education, the lead assigns the patient to a therapist who has the ability to perform that function. The lead also helps coordinate supplemental staffing. There are two other physical therapy departments in the Hospital with which the outpatient unit may loan or borrow therapists as needed. In the case of overstaffing, the lead will communicate with the other departments and ask if they need help. If additional help is not needed, the lead may tell the therapists that their work is not needed and that they may go home, but the lead has to get permission of the supervisor.[14] The department also serves as part of a pool with other physical therapy providers not related to the Hospital. The lead has the authority to ask for the return of therapists loaned to those facilities but informs the assistant director as a ''courtesy.''

Other responsibilities of the lead include writing an annual quality improvement plan or report and facilitating data collection for the report. The lead also is responsible for writing new policy plans and updating others. The lead is responsible for obtaining unusual incidents reports (not defined in the record), and for some case management functions, utilization review, communicating with insurance companies, and obtaining authorization for reimbursement from insurance companies. The lead helps complete annual written evaluations, but ''not independently.'' On occasion, the lead may make recommendations, such as that a thera-

ployee. On September 21, 1994, the Board denied the Employer's request for review regarding the contentions that this employee should be excluded on community-of-interest grounds and because she is a managerial employee. Our discussion of this employee is limited to her contested supervisory status.

[14] The record is unclear as to which ''supervisor'' this testimony refers.

pist needs education, in which case, the lead may prepare the educational tools. The record does not show how often the lead makes such recommendations or whether they are routinely followed.

II. LEGAL PRINCIPLES

A. *The Act*

Section 2(3) of the Act excludes from the definition of ''employee'' ''any individual employed as a supervisor.'' Section 2(11) defines supervisor as:

> any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not of a routine or clerical nature, but requires the use of independent judgment.

Section 2(11) is to be interpreted in the disjunctive and ''the possession of any one of the authorities listed in [that section] places the employee invested with this authority in the supervisory class.'' *Ohio Power Co. v. NLRB*, 176 F.2d 385, 387 (6th Cir. 1949), cert. denied 338 U.S. 899 (1949).

In enacting Section 2(11) of the Act, Congress distinguished between true supervisors who are vested with ''genuine management prerogatives,'' and ''straw bosses, lead men, and set-up men'' who are protected by the Act even though they perform ''minor supervisory duties.'' *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 280–281 (1974) (quoting S. Rep. No. 105, 80th Cong., 1st Sess., 4 (1947). Senate Rep. No. 105 also stated that the committee took ''great care'' that employees excluded from the coverage of the Act ''be truly supervisory'' and that the amendment exclude only ''the supervisor vested with such management prerogatives as the right to hire or fire, discipline, or make effective recommendations with respect to such actions.'' NLRB, Legislative History of the Labor Management Relations Act of 1947, 410. ''Responsibly to direct'' was added to the Senate bill shortly before its enactment by Senator Flanders, who explained that it was added to include ''essential managerial duties'' not otherwise covered by the other indicia. Leg. Hist. at 1303.

There is no contention before us that the RN charge nurses or other alleged supervisory RNs have the authority to hire, transfer, suspend, lay off, recall, promote, discharge, reward, or discipline other employees or to adjust their grievances, or to effectively recommend such action. The Employer contends only that these disputed RNs responsibly direct and assign employees and that their exercise of such authority requires the use of independent judgment.[15]

Applying the indicia of assignment and responsibly to direct to the facts of a specific case is often difficult. There are no hard and fast rules; instead, each case turns on its own particular facts. Clearly, not all assignments and directions given by an employee involve the exercise of supervisory authority. As succinctly stated by the Fifth Circuit in *NLRB v. Security Guard Service*, 384 F.2d 143, 151 (5th Cir. 1967):

> If any authority over someone else, no matter how insignificant or infrequent, made an employee a supervisor, our industrial composite would be predominantly supervisory. Every order-giver is not a supervisor. Even the traffic director tells the president of a company where to park his car.

Consequently, the Board analyzes each case in order to differentiate between the exercise of independent judgment and the giving of routine instructions, between effective recommendation and forceful suggestion, and between the appearance of supervision and supervision in fact. *McCullough Environmental Services*, 306 NLRB 565 (1992), enf. denied 5 F.3d 923 (5th Cir. 1993). Where the supervisory issue involves, as here, professional RNs, this analysis is compounded by the difficulty, to paraphrase the testimony of the Hospital's director of the neuromuscular/skeletal care center, of explaining the additional authority a charge nurse has without taking away from the professional responsibility of an RN for the quality of patient care. An additional compounding factor is that Section 2(11) requires that a supervisor use independent judgment in the exercise of any of the listed indicia and that Section 2(12) of the Act includes in the definition of professional employee ''the consistent exercise of discretion and judgment.''[16]

B. *Patient Care Analysis*

These compounding factors are perhaps most visible in the health care industry. Nurses at times must make immediate life-or-death decisions involving critically ill patients, and in so doing, may instruct others, including other nurses, about what needs to be done. The possibility that severe consequences might flow from a

[15] Although there are references in the record that the disputed RNs' have a role in evaluations and discipline, as well as a footnote reference to disciplinary action in the Employer's brief, the Employer has not asserted those indicia as reasons for finding that the disputed RNs are statutory supervisors. Accordingly, we find that our dissenting colleague's reliance on those factors is misplaced. Nonetheless, we have set forth such evidence in our statement of facts as we believe those facts are relevant to the extent the evidence sheds light on the disputed RNs' direction of employees.

[16] The Board defines technical employees, such as licensed practical nurses (LPNs), as those who also use independent judgment. *Fisher Controls Co.*, 192 NLRB 514 (1971).

professional's misjudgment does not necessarily make that judgment supervisory; critical judgment is the quintessence of professionalism.[17] If the nurse giving those instructions is an alleged supervisor, the Board must determine whether the instructions are sufficient to render the nurse a statutory supervisor.

It was largely in response to these compounding factors that the Board developed the so-called ''patient care analysis'': a charge nurse's assignment and direction of other employees did not involve the exercise of supervisory authority because it stemmed from the charge nurse's professional (or in the case of an LPN, technical) judgment in the interest of patient care and was not ''in the interest of the employer.'' *Northcrest Nursing Home*, 313 NLRB 491, 493–494 (1993). Thus, the patient care analysis was a tool designed, in part, to avoid the confusing dichotomy between the judgment exercised by all nurses due to their professional or technical training and the exercise of independent judgment by a supervisor. That tool, however, was rejected by the Supreme Court, as discussed below.

III. THE SUPREME COURT'S DECISION

In *NLRB v. Health Care & Retirement Corp*., 114 S.Ct. 1778 (1994), the Supreme Court majority rejected the Board's patient care analysis, i.e., the Court found that the Board's use of ''in the interest of the employer'' was ''inconsistent with both the statutory language and this Court's precedents'' (id. at 1783) ''and has no relation to the ordinary meaning of that language.'' (Id. at 1785.) The Court's decision, however, by its terms, is restricted to rejecting the Board's misuse of ''in the interest of the employer.'' The decision states:

> The Board defends its test by arguing that phrases in § 2(11) such as ''independent judgment'' and ''responsibly to direct'' are ambiguous, so the Board needs to be given ample room to apply them to different categories of employees. That is no doubt true, but it is irrelevant in this particular case because the interpretation of those phrases is not the underpinning of the Board's test. [Id. at 1783.]

The Court made doubly clear that its decision was narrowly limited: ''We note further that our decision casts no doubt on Board or court decisions interpreting parts of § 2(11) other than the specific phrase 'in the interest of the employer.''' (Id. at 1785.)[18] The Court even suggested how the Board should proceed:

> [W]hether one or more of the 12 listed activities is performed in a manner that makes the employee a supervisor is, of course, part of the Board's routine and proper adjudicative function. In cases involving nurses, that inquiry no doubt could lead the Board in some cases to conclude that supervisory status has not been demonstrated. [Ibid.]

The Court also specifically held, ''The Act does not distinguish professional employees from other employees for purposes of the definition of supervisor in § 2(11).'' (Id. at 1784.) The Court recognized that there may be some tension between the Act's exclusion of supervisors and its inclusion of professionals but held that there is no authority to resolve that tension ''by distorting the statutory language.'' (Ibid.) The Court indicated that its holding was, on this point, narrow and that Section 2(11) must drive Board policy, not the other way around. The Court again suggested how the Board should proceed:

> To be sure, in applying § 2(11) in other industries, the Board on occasion reaches results reflecting a distinction between authority arising from professional knowledge and authority encompassing front-line management prerogatives. It is important to emphasize, however, that in almost all of those cases (unlike in cases involving nurses) the Board's decisions did not result from manipulation of the statutory phrase ''in the interest of the employer,'' but instead from a finding that the employee in question had not met the other requirements for supervisory status under the Act, such as the requirement that the employee exercise one of the listed activities in a non-routine manner. [Id. at 1785.]

The Court in conclusion stated:

[17] It would appear that courts may occasionally have been influenced by the possible adverse impact of such judgment by professional, technical, or otherwise highly skilled employees in finding supervisory status. See, e.g., *McCullough Environmental Services v. NLRB*, 5 F.3d 923 (5th Cir. 1993), in which the court's analysis referred to the lead operator's need to know how to operate a complex waste treatment plant to prevent disruption during emergencies. See also *Maine Yankee Atomic Power Co. v. NLRB*, 624 F.2d 347 (1st Cir. 1980), in which the court referred to the responsibility entrusted to the shift operation supervisor over the entire nuclear power plant. The Board also may be guilty of such misdirection. In *Avon Convalescent Center*, 200 NLRB 702, 706 (1972), the Board, in finding charge nurses to be supervisors, adopted the judge's decision which relied in part on the nurses' decisions regarding ''sick patients whose critical needs may momentarily require variations in procedures.''

[18] The Board's brief to the Supreme Court in *Health Care & Retirement* stated that ''to the extent that the nurses' actions were not purely routine, the nurses acted in the interest of patient care.'' Contrary to our dissenting colleague, we would not characterize the Board as having accepted the proposition that the nurses there exercised supervisory powers. Moreover, no member of this Board subscribed to the patient care analysis undertaken by the Board in *Northcrest*, supra, i.e., ''in the interest of the employer,'' which was at the time before the Court in *Health Care & Retirement*.

> If the case presented the question whether these nurses were supervisors under the proper test, we would have given a lengthy exposition and analysis of the facts in the record. [Ibid.]

In sum, the Court held that the Board's patient care analysis relying on ''in the interest of the employer'' was an impermissible shortcut, that there are no hard-and-fast rules, but that the Board should analyze the 12 listed statutory indicia in detail and on a case-by-case basis.

Consequently, the Board is once again faced with the difficulty of explaining the difference between the exercise of professional responsibility and the exercise of statutory supervisory authority. As set forth above, the Supreme Court has suggested that the Board accomplish this task by analyzing, in each case, whether the contested individuals meet all the statutory requirements for supervisory status. It is for these reasons that we invited oral argument and amici briefs, with specific questions about the impact of the Supreme Court's decision and the proper interpretation of ''assign,'' ''responsibly to direct,'' ''routine,'' and ''independent judgment.''

IV. ASSIGNMENT

The term ''assignment'' has not presented as much difficulty as the phrase ''responsibly to direct.'' It clearly differs from responsible direction in that it refers to the assignment of an employee's hours or shift, the assignment of an employee to a department or other division, or other overall job responsibilities. It would also include calling in an employee or reassigning the employee to a different unit. Whether assignment also includes ordering an employee to perform a specific task is, however, less clear. Indeed at oral argument it was contended that the assignment of a particular task to an employee is not an assignment as contemplated by Section 2(11); rather Section 2(11) contemplates only the assignment of employees. Certainly there are times when the assignment of tasks overlaps with direction. For example, ordering a nurse to take a patient's blood pressure could be viewed as either assigning the nurse to that procedure or directing the nurse in the performance of patient care. Because the distinction between assignment and direction in these circumstances is unclear, the Board has often analyzed the two statutory indicia together.

As both the Board and the courts have recognized, not every act of assignment even of employees constitutes statutory supervisory authority. As with every supervisory indicium, assignment must be done with independent judgment before it is considered to be supervisory under Section 2(11). Thus, routine or clerical assignments are not supervisory; only those requiring the exercise of independent judgment are. Although the test is easily stated, application often depends on a careful analysis of the facts of each case. In doing so the Board and the courts have followed certain guiding principles. For example, work assignments made to equalize employees' work on a rotational or other rational basis are routine assignments;[19] assignments based on assessment of employees' skills when the differences in skills are well known have been found routine;[20] asking, without authority to require, employees to come in early or work late is routine;[21] and adjusting employees' schedules to meet the vagaries of manpower needs is not necessarily supervisory.[22]

As set forth below, in this case we conclude that whatever authority the charge nurses have to ''assign'' RNs and other staff members, whether it be characterized as assignment of employees or assignment of tasks, is not authority that requires the use of independent judgment within the meaning of Section 2(11). Accordingly, it is unnecessary to reach the issue of the exact parameters of the term ''assignment'' under Section 2(11).

V. RESPONSIBLY TO DIRECT

This statutory indicium, as discussed above, was added at the 11th hour by Senator Flanders. He explained that it was not meant to include minor supervisory functions performed by lead employees, straw bosses, etc. Rather, the addition was designed to include those individuals who exercised the essence of supervision without having the authority to exercise any other statutory indicium.[23]

---

[19] *Ohio Masonic Home*, 295 NLRB 390, 395 (1989).

[20] *Clark Machine Corp.*, 308 NLRB 555, 555–556 (1992).

[21] *Children's Habilitation Center v. NLRB*, 887 F.2d 130, 134 (7th Cir. 1989).

[22] *Beverly Manor Convalescent Centers v. NLRB*, 661 F.2d 1095, 1100 (6th Cir. 1981).

[23] Our dissenting colleague relies on Senator Flanders' use of the terms ''personal experience, training, and ability'' as the definitive meaning of the addition of ''responsibly to direct'' as a Sec. 2(11) indicium. As discussed below, however, our decision does not turn on the definition of ''responsibly to direct'' but on whether the charge nurses' ''direction'' of others requires the use of independent judgment. Moreover, our colleague has, in our opinion, taken the above terms out of their introductory context and has thereby distorted what Senator Flanders intended. The text from which these terms were taken reads:

> In fact, under some modern management methods, the supervisor might be deprived of authority for most of the functions enumerated and still have a large responsibility for the exercise of personal judgment based on personal experience, training, and ability. He is charged with the responsible direction of his department and the men under him. He determines under general orders what job shall be undertaken next and who shall do it. He gives the instructions for its proper performance. If needed, he gives training in the performance of unfamiliar tasks to the worker to whom they are assigned.
>
> Such men are above the grade of ''straw bosses, lead men, set-up men, and other minor supervisory employees'' as enumerated in the [Senate] report. Their essential managerial duties are

Continued

The Board has only rarely sought to define the parameters of ''responsibly to direct.'' Shortly after Section 2(11) was added to the Act, the Board in *Ohio Power Co.*, 80 NLRB 1334 (1948), attempted to describe the limits of the term.[24] Historically, however, the Board has not continued in subsequent cases to refine the meaning of this statutory indicium. Instead, the Board generally has treated ''responsibly to direct'' in conjunction with Section 2(11)'s qualifying language that the exercise of any statutory indicia ''is not of a merely routine or clerical nature, but requires the use of independent judgment.'' The reliance on this analytical method is neither evasive nor unreasonable. It does not ignore the indicium but rather recognizes the overriding requirement expressed in the qualifier.[25] The general success of this approach for over 40 years demonstrates its plausibility.

The Board, however, has experienced some difficulty in applying this method in at least some cases involving professional or technical employees who are at the same time engaged both in their professional or technical work and in directing other employees. This is because, as noted earlier, a professional or technical employee's work necessarily involves judgment and because it may be difficult to separate that judgment from the supervisory independent judgment of Section 2(11) of the Act. Nevertheless, when a professional gives directions to other employees, those directions do not make the professional a supervisor merely because the professional used judgment in deciding what instructions to give. For example, designing a patient treatment plan may involve substantial professional judgment, but may result in wholly routine direction to the staff that implements that plan. Independent judgment must be exercised in connection with the Section 2(11) function if the actor is to be deemed a statutory supervisor; use of judgment in related areas of a professional or technical employee's own work does not meet the statute's language. Indeed, in *Health Care & Retirement*, supra, 114 S.Ct. at 1785, the Supreme Court seemed to recognize this concern by noting that the Board has drawn a distinction between the ''authority arising from professional knowledge'' and the ''authority encompassing front-line management.''

In cases involving a professional's authority to direct other employees, this distinction is not, however, always easily drawn. In light of this difficulty, we have considered, as suggested at oral argument, whether the Board should forgo the traditional method of analyzing the indicium under the rubric of independent judgment and instead focus on the term ''responsibly to direct'' to determine cases raising this issue.

Although the Board has not refined its initial attempt in *Ohio Power Co.*, supra, to set parameters to this indicium, the courts have on occasion done so. The Sixth Circuit, in the *Ohio Power* case applied the test that, ''To be responsible is to be answerable for the discharge of a duty or obligation.'' *Ohio Power Co. v. NLRB*, 176 F.2d 385, 387 (6th Cir. 1949), cert. denied 338 U.S. 899 (1949).[26] Other courts of appeals have endorsed this definition, most recently the First Circuit in *Northeast Utilities Service Corp.*, 35 F.3d 621 (1st Cir. 1994).[27] That court also suggested that ''[i]t may profit the Board to reexamine its views'' regarding ''the quasi-professional, quasi-overseer employee'' which neither the Board nor the courts contemplated when they ''set upon the task of defining supervisor.'' Perhaps the most complete definition is in *NLRB v. KDFW-TV, Inc.*, 790 F.2d 1273, 1278 (5th Cir. 1986), in which the court held:

> ''To be responsible is to be answerable for the discharge of a duty or obligation.'' In determining

best defined by the words ''direct responsibly,'' which I am suggesting. [NLRB, Legislative History of the Labor Management Relations Act of 1947, 1303.]

[24] Id. at 1338–1339, the Board stated:

Legislative history indicates, however, that the broad scope implied in a literal construction of the authority ''responsibly to direct'' was not intended by Congress, but rather that a specific qualified meaning was attached to this phrase.

Senator Flanders, in offering this additional authority as an amendment to the definition of ''supervisor'' in the Senate bill, apparently desired specifically to encompass those individuals who engage regularly in the basic acts of supervision but who do not exercise the other specific powers of supervision set forth in the definition, e.g., power to hire, discharge, and effect changes in employment status, which are vested exclusively in a ''personnel manager or department.'' These individuals, the Senator asserted, ''responsibly direct'' in the exercise of the remaining ''basic'' functions of supervision, and still ''are above the grade of straw bosses, lead men, set-up men, and other minor supervisory employees.''

It is evident, therefore, that individuals having the authority ''responsibly to direct'' contemplated in Section 2(11) fall within a narrow area lying between those ''above the grade of straw bosses, lead men, set-up men and other minor supervisory employees,'' and those who do not possess *any* of the other specific authorities enumerated in the Act's definition. Apart from Senator Flanders' hypothetical illustration, what constitutes such responsible direction must necessarily be determined upon the facts in each case. Indeed, we have held before and after the amendments that fringe individuals, such as '' lead men'' and ''set-up men,'' under certain circumstances, are supervisors, and, under other circumstances, that they are not supervisors. [Citations omitted.]

[25] The basis for this approach is not that the terms ''responsibly to direct'' and ''independent judgment'' are synonymous, but that an employee who exercises independent judgment in a nonroutine manner in directing other employees is likely to have been delegated substantial authority by the employer to carry out directions to those employees.

[26] Reviewing 78 NLRB 1134 (1948) and the related representation case reported at 73 NLRB 384 (1947) as supplemented by 80 NLRB 1334 (1948).

[27] The First Circuit's endorsement of the accountability definition in *Northeast Utilities* was a reendorsement. See *Maine Yankee Atomic Power Co. v. NLRB*, 624 F.2d 347, 361 (1st Cir. 1980). Other court decisions endorsing the definition include *NLRB v. Adam & Eve Cosmetics*, 567 F.2d 723, 728 (7th Cir. 1977); and *NLRB v. Daily News Tribune*, 283 F.2d 545, 549–550 (9th Cir. 1960).

> whether ''direction'' in any particular case is responsible, the focus is on whether the alleged supervisor is ''held fully accountable and responsible for the performance and work product of the employees'' he directs. Thus, in *NLRB v. Adam & Eve Cosmetics, Inc.* . . . for example, the court reversed a Board finding that an employee lacked supervisory status after finding that the employee had been reprimanded for the performance of others in his department. [Citations omitted.]

The courts of appeals' definition of ''responsible'' as ''answerable'' or ''accountable'' finds support in the ordinary meaning of ''responsible.'' *Random House Webster's College Dictionary* (1991) defines ''responsible'' as ''accountable, as for something within one's power.'' That source also gives a secondary definition as ''reliable or dependable, as in conducting one's affairs.'' More to the point, *Webster's New International Dictionary, Second Edition* (1934),[28] defines ''responsible'' as ''likely to be called upon to answer,'' and ''creditable or chargeable with the result.'' Accord: *Webster's Third New International Dictionary* (1971). The plain meaning of ''responsible'' is not, however, sufficiently precise to fully resolve this issue. The definition ranges from being held accountable for one's own actions, to being held accountable for the actions of others, and to being reliable. To that extent, ''responsibly to direct'' is ambiguous, which the Supreme Court apparently acknowledged in *Health Care & Retirement*, supra at 1783.

In light of the plain meaning of ''responsible,'' the legislative history, and the general imprimatur of a number of courts of appeals, it may be appropriate in some cases for the Board to determine supervisory status by deciding whether the individual's authority to direct includes the authority to do so ''responsibly.'' Any analysis of responsible direction must, as in any case involving whether an employee is a statutory supervisor, be determined on a case-by-case basis. We also believe that this approach should be supplementary to the Board's traditional approach of resolving the issue of responsible direction by examining whether the employees at issue exercise independent judgment.

We fully expect, therefore, that the analysis of most cases raising supervisory issues will be made pursuant to the Board's traditional approach of analyzing whether the direction is done with independent judgment. We also believe that it is preferable not to develop a full analysis of the term ''responsibly to direct'' in the abstract. Thus, only in those cases in which the traditional analysis does not fully account for the facts presented will it be necessary to analyze the meaning of ''responsibly to direct.'' This, however, is not such a case. Consequently, the analysis will not be undertaken here but will be left for those cases in which resolution of the supervisory issue is not amenable to the traditional method of analysis. This, case, like most, can be analyzed under the Board's traditional approach.

Using this approach, the Board has devised a number of guiding principles involving the authority to direct. Since enactment of Section 2(11),[29] the Board has, with court approval, distinguished supervisors who share management's power or have some relationship or identification with management from skilled nonsupervisory employees whose direction of other employees reflects their superior training, experience, or skills. *Southern Bleachery & Print Works*, 115 NLRB 787 (1956), 118 NLRB 299 (1957), enfd. 257 F.2d 235 (4th Cir. 1958), cert. denied 359 U.S. 911 (1959); accord: *Security Guard Service*, 154 NLRB 8 (1965), enfd. 384 F.2d 143 (5th Cir. 1967). The Board has also recognized that making decisions requiring expert judgment is the quintessence of professionalism; mere communication of those decisions and coordination of their implementation do not make the professional a supervisor. See, e.g., *General Dynamics Corp*., 213 NLRB 851, 859 (1974), in which the Board found that professionals who were serving as project leaders were not vested with true supervisory authority because they, ''for indeterminate periods of time, 'supervise' coequals who, in turn, later 'supervise' their equals while simultaneously being 'supervised' by their coequals.'' Similarly, the Board has held that project managers at an architectural and engineering firm were not supervisors as they ''merely provide professional direction and coordination for other professional employees.'' *Skidmore, Ownings & Merrill*, 192 NLRB 920 (1971); accord: *Wurster, Bernardi, & Emmons, Inc*., 192 NLRB 1049 (1971).

The common theme of these and other similar cases is that Section 2(11) supervisory authority does not include the authority of an employee to direct another to perform discrete tasks stemming from the directing employee's experience, skills, training, or position, such as the direction which is given by a lead or journey level employee to another or apprentice employee, the direction which is given by an employee with specialized skills and training which is incidental to the directing employee's ability to carry out that skill and training, and the direction which is given by an employee with specialized skills and training to coordinate the activities of other employees with similar specialized skills and training.

Our dissenting colleague asserts that we ''have ignored the substantial degree of independent judgment

[28] This was the then current edition when Congress enacted Sec. 2(11) of the Act. The definition has not changed substantially since then.

[29] Many of the principles used to determine supervisory status were, however, developed by the Board prior to enactment of Sec. 2(11). See, e.g., *Douglas Aircraft Co*., 50 NLRB 784, 787 (1943).

which charge nurses possess.'' In our opinion, the dissent improperly transposes the judgment exercised by RNs from their status as professionals to their status when serving as charge nurses. Our basic disagreement with our dissenting colleague is that he fails to fully recognize that the ''essence'' of the job of all RNs, and not just charge nurses, is ''judgment.'' The evidence in this case demonstrates that all RNs, in whatever their capacity, regularly exercise judgment as professional employees that differs little in effect from any additional authority exercised by RNs when serving as charge nurses.[30] As explained above, the essence of professionalism requires the exercise of expert judgment and the essence of supervision requires the exercise of independent judgment. And as detailed below, the alleged supervisory independent judgment of charge nurses when examined in detail becomes indistinguishable from the professional judgment exercised by all RNs.[31]

Accordingly, we turn to the application of the above-discussed legal principles to the facts of this case. As previously stated, the sole Section 2(11) indicia asserted by the Employer are assignment and responsible direction of employees.

VI. DISCUSSION

A. *Charge Nurses*

1. Generally

Each of the four care centers in which there are charge nurses at issue differs in the method of selecting those RNs who may be designated as charge nurses, in the percentage of RNs who have been so selected, and in the percentage of time any selected RN serves as charge nurse. These variations extend to the different departments in the centers, to the different units within the departments, and to the different shifts in the units, departments, and centers. The range of time spent by the designated RNs as charge nurses varies from an estimated 5–95 percent of the time.

Despite these differences, the actual duties of charge nurses throughout these four care centers are otherwise substantially the same. Because of these similarities we shall not separately analyze the duties of each department or unit, but shall provide a generalized analysis, noting any significant differences among the centers, departments, units, and shifts.

There are institutional limits to the general authority of charge nurses. The centers that employ the disputed charge nurses, with one departmental exception discussed below, uniformly also employ supervisory RNs. The supervisory RNs, with the exception of the emergency services center, serve as charge nurses when they are present and actively involved[32] in patient care. The presence of supervisory RNs limits the times when RN charge nurses are ''in charge.'' Realistically, this also means that the charge nurses are relieved from the administrative tasks for which the supervisory RN is responsible. Also, at all times that an RN serves as a charge nurse, a shift coordinator is present in the Hospital and available for consultation by the charge nurse. The presence of the shift coordinator serves as a buffer to relieve the charge nurses from having to make all decisions on their own.

The rehabilitation department in the neuromuscular/skeletal center is the department that does not employ RN supervisors. That department also differs in that all its RNs work only part-time. Yet another difference is that this department employs therapists and rehabilitation employees who apparently are outside the RNs' line of supervision. We do not view these differences as materially significant. In particular, the absence of RN supervisors does not affect the functions of the RN charge nurses.[33] In the other areas of the Hospital, with the exception of the emergency services center, RNs serve as charge nurses only when the RN supervisor is not present or not actively involved in patient care. Simply stated, in all areas of the Hospital, except emergency services, RNs serve as charge nurses only in the absence of RN supervisors.

2. Assignment

a. *Discussion*

All charge nurses have limited authority to assign employees. The monthly staffing schedules are prepared by the centers' directors or supervisors apparently without charge nurse input. At the beginning of a shift, charge nurses assign patients to employees based on the needs and acuity of the patients and the skills of the staff. Charge nurses may also look at the mix of staff—i.e., the number of RNs, LPNs, and aides

[30] We believe that our dissenting colleague has failed to appreciate and therefore has failed to fully address the dichotomy presented by Sec. 2(11) and (12) of the Act. We do recognize, as our dissenting colleague states, that ''each and every section of the Act is to be given effect.'' But we also appreciate that sound administrative practice requires that the Board should not apply or construe one provision of the Act in isolation, but that we must interpret any one provision in light of the entire statutory scheme. *Southerland Statutory Construction*, sec. 46.05 (5th ed.); accord: *NLRB v. Lion Oil Co*., 352 U.S. 282, 288 (1957) (''In expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the whole law, and to its object and policy.'').

[31] We agree with our dissenting colleague that the Board should use the same standard in unfair labor practice cases as in representation cases. The determination of supervisory status is, however, by its very nature fact intensive. Accordingly, we will continue to judge each case based on its particular facts and under the standards here set forth.

[32] That is, when they are not on administrative duties.

[33] The absence of RN supervisors in the department merely means that there is no intermediate level of supervision between the employees and the department director.

available—and which patients RNs may have had the day before. The authority to make daily assignments, however, is limited in practice. For example, the director of the medical, surgical, and oncology center testified that non-charge staff RNs are responsible for assessing patients' conditions and needs. Also, a charge nurse in that center testified that she did not tell RNs what to do because they are all professionals who know their jobs. In addition, a pediatrics charge nurse in the women's and children's center described daily assignments as a ''collaborative effort.'' Staff RNs also have traded assigned patients on their own.

Charge nurses monitor the arrival of the RNs to verify attendance. If an RN is absent, the charge nurse is responsible for finding a replacement.[34] In some centers, the charge nurses will first check with other departments and units within their center to see if a loaner is available. In all centers, the charge nurses check with the shift coordinator to see if a replacement is available elsewhere in the Hospital. If the shift coordinator is unable to find a replacement, the charge nurse may call an employee into work or authorize overtime.[35] In calling in employees, the charge nurses generally work from staffing lists.

At the beginning of the shift, charge nurses also determine if they are understaffed due to a high patient load.[36] They report to the shift coordinator, who may send a loaner, depending on the situation. If still understaffed, the charge nurses may call in RNs or authorize overtime. The charge nurses may request employees to work overtime; however, they cannot order employees to do so. In any event, there is testimony that it is the shift coordinator who effectively decides if extra help is warranted. In addition, RNs in the medical, surgical, and oncology center and in the women's and children's center testified that they work overtime without any authorization from the charge nurse, i.e., they just stay over and write the amount of time on the shift report.

Similarly, if the units are overstaffed due to low census, the charge nurses inform the shift coordinator. If the extra RNs are not needed elsewhere in the Hospital, the charge nurses may send employees home early. There is no evidence that the charge nurses have the authority to order an RN to leave early. In fact, there is testimony that the shift coordinator has overruled a charge nurse's decision to send an RN home. In addition there is testimony from a charge nurse in the women's and children's center that RNs are given time off on a strict rotational basis and that when her turn came she left early, even though she was serving as charge nurse at the time. In the medical, surgical, and oncology center, the charge nurse asks for volunteers.

Charge nurses at the end of a shift determine the staffing needs for the next shift.[37] The charge nurses also attempt to make any adjustments by calling the shift coordinator or asking RNs to stay over. Charge nurses also have a limited role in scheduling or authorizing breaks. In the emergency services center, e.g., breaks are determined on a rotating basis. Typically, in all centers, the RN asks the charge nurse if it is a good time to take a break. Depending on the need for the RN to cover other patients, the charge nurse will approve or disapprove the break.

Although the evidence regarding charge nurses' assignments is largely limited to staff RNs, there is some evidence as to their assignment of LPNs and aides, but most often that depends on the number of LPNs and aides present at any one time.[38] Thus, for example, if there is only one aide on the shift, the aide covers the whole unit; if there are two aides, the unit is split between them. There is testimony that the staff RNs, rather than charge nurses, tell aides what to do.

b. *Analysis*

We agree with the Regional Director that the record evidence does not establish that charge nurses' assignment of RNs is anything more than a routine clerical task. In the first instance, charge nurses do not prepare monthly schedules, the type of assignment most closely identified with essential managerial functions requiring the use of independent judgment. There was generalized testimony that, in making daily assignments, charge nurses assess patients' needs and RNs' skills. There is, however, little if any evidence that patients' needs or nurses' skills differ significantly within a particular unit. In addition there is evidence that the staff RNs assess patients' needs and acuities; such assessments are part of their professional responsibilities. Nor is there any evidence that RN charge nurses are any more knowledgeable about the skills of RNs than

[34] There is only limited evidence that charge nurses ever seek replacements for LPNs or aides.

[35] There is little testimony regarding how often the shift coordinator is called, how often a loaner is made available, or how often RNs are asked to work overtime. There is testimony that in the women's and children's center obtaining a replacement occurs about three quarters of the time. In emergency services, requests to employees to stay overtime happen during at least one shift every day. Emergency services, however, uses overlapping shifts, which would facilitate this practice. Also, in apparent contrast to other centers, emergency services has a list of contingent RNs from which call-ins are made. There is also testimony that for emergency services the shift coordinator can usually find extra help from elsewhere in the Hospital for the few hours usually needed by the department.

[36] There is limited testimony about general guidelines on the RN to patient ratio. The record, however, is unclear to what extent the Hospital maintains such guidelines.

[37] There is also a lack of evidence on what basis the staffing needs are determined. The record is unclear whether, in emergency services, this is done on all shifts or only the night shift.

[38] The evidence is incomplete as to the number of LPNs and aides serving in each of the centers, departments, units, and shifts.

the RNs themselves. Thus, for example, an RN in oncology testified that nurses who are good on IVs are well known in the unit and may be sought out by other RNs to start IVs for their patients. There is also evidence that matching RNs to patients is in some units a collaborative process. RNs also trade patients. Charge nurses' daily assignments do not require any independent judgment that goes beyond the professional judgment exercised by all RNs. Such assignment does not involve the independent judgment required of a supervisor. *Clark Machine Corp.*, 308 NLRB 555, 555–556 (1992).

Charge nurses' authority to call in other staff or to let staff off early is similarly curtailed. In the case of absences, the decision is obviously clerical; either all scheduled staff have reported or they have not. And before deciding to call someone in, the charge nurses check with the shift coordinator. It also appears that in calling someone in, charge nurses have the names of staff members who may be available. More importantly, the charge nurses cannot require someone to come in. Assessing whether there is a high or low patient census warranting calling in extra help or letting staff off early is not significantly more complicated than counting the number of patients. In any event, staffing changes are effectively determined by the shift coordinator. Preparing for the staffing needs of the next shift is at most no more complicated than seeing to those needs during the shift. A charge nurse may ask RNs to stay over or to come in early; however, they have no authority to compel employees to do so. This limited authority requires only routine judgment. *Children's Habilitation Center v. NLRB*, 887 F.2d 130, 134 (7th Cir. 1989). In selecting whom to ask to stay over, charge nurses ask for volunteers or sometimes use rotational lists. Charge nurses use similar procedures in deciding which staff RNs may leave early. Balancing work assignments among staff members or using other equitable methods does not require the exercise of supervisory independent judgment. *Ohio Masonic Home*, 295 NLRB 390, 395 (1989). Accordingly, we find that charge nurses do not exercise supervisory independent judgment in calling in other staff, requesting overtime, or letting staff off early.

Charge nurses' authority in determining breaks is also curtailed. Generally, break times are initiated by requests from staff RNs at times convenient to the RNs. The charge nurses' approval or disapproval of the requests is based on their view of the workload of the entire unit rather than the RNs' views of their own workloads. This is a routine clerical judgment. A break is not given if RNs are needed elsewhere in the unit; otherwise it is.

Charge nurses' assignments of aides and LPNs is also merely clerical or routine and does not require the use of independent judgment. It does not require much judgment to decide that, if there is one aide, the aide covers the entire unit, or if there are two aides, the unit is split between them. There is no evidence that assignment of LPNs is any more complex.

3. Direction

a. *Discussion*

Charge nurses are generally responsible for coordinating patient care within their areas of responsibility. They are responsible for preparing the end-of-shift reports. Those reports describe the patient census, the RNs who worked, and any problems that occurred, as well as how they were handled. They are also used to report patients' complaints, equipment failures and shortages, recommendations for program changes, system changes, further education, or anything else that must be communicated to management for followup. The weight of the evidence shows that staff RNs also make entries on these reports.

Charge nurses monitor other employees' skills and performances, intervene in the case of serious problems in procedures, patient care, or customer relations, and report lesser problems in the end-of-shift reports. On occasion, they have intervened in disputes between staff RNs over patient assignments. Staff RNs, however, are also expected and required to report any problems in the care given patients. There is evidence that staff RNs have done so and have personally intervened, including an RN who reported deficiencies in a charge nurse's performance. This is part of their professional responsibility. As one staff nurse testified, ''As nurses we learn right off the bat in nursing school that you are first and foremost a patient advocate.'' Or as the director of the medical, surgical, and oncology center testified, ''Based on state practices, I don't think any RN could ignore or abandon an acute situation.'' The director of another center testified that staff RNs are involved in identifying skill deficits, and the charge nurse in developing an educational plan. No details or examples, however, were given.

Charge nurses have been asked by management for their evaluations of staff members, but so have staff RNs. One center director testified that a charge nurse has a more global responsibility. Charge nurses, however, do not make or have direct input into formal evaluations. All RNs prepare peer review evaluation forms for the RNs they follow, rating the RNs' work from excellent to poor. Charge nurses have also served on panels evaluating applicants for employment, but it is unclear whether this is in a charge nurse or RN capacity.

There was no testimony specifically referring to how charge nurses may direct the work of LPNs or aides other than the limited testimony about assignments discussed above.

b. *Analysis*

We agree with the Regional Director that the charge nurses' direction of employees does not require the use of independent judgment within the meaning of Section 2(11) of the Act but is merely of a routine or clerical nature. To be sure, charge nurses exercise considerable judgment in assessing patients' conditions and treatment, but that is an exercise of their professional judgment as RNs which is shared by all staff RNs at the Hospital.

The end-of-shift reports are used for recording events and reporting them to management. Such recording and reporting functions are clerical in nature. The monitoring of employees' skills by the charge nurses is a routine function of their professional responsibilities as RNs and is shared by all RNs. Their role in evaluating employees is similar to the role of all RNs in their peer reviews. Furthermore, there is no evidence that their evaluations are effective or even to what extent they are used by management in making the formal evaluations.

In sum, RN charge nurses serve as a classic example of team leaders responsible for coordinating the team's work and for serving as a center for communication. This role is especially demonstrated by the rotational assignment of RNs as charge nurses. Statutory supervisory authority is not shown by the limited authority of a charge nurse team leader on one day to ''supervise'' coequal RNs, some of whom may on another day ''supervise'' their equals including the charge nurse. *General Dynamics Corp.*, 213 NLRB 851, 859 (1974).

4. Conclusion

In agreement with the Regional Director, we conclude that the record has failed to establish that the RN charge nurses are supervisors within the meaning of Section 2(11) of the Act. Accordingly, they are included in the petitioned-for unit and are eligible to vote in the election.

B. *Other Supervisory Issues*

1. Home health care team leaders and team leader assistants

a. *Assignment*

(1) Discussion

Team leaders serve to coordinate the RN home health care teams. Team leader assistants fill in for absent team leaders. The leaders are responsible for a patient's overall case management, including referrals, coordination with other disciplines, documentation for physicians, and completing the extensive paperwork. Leaders assign patients to RNs on their teams based on the needs of patients and the skills of the RN, on achieving equitable assignments, and on the geographical areas where the RN has current patients. Leaders assign patients; RNs schedule when they will see the patients. RNs also have some input into assignments.

Leaders' assignments change on a daily basis because of changes in patients' conditions, availability of patients, and staff RNs' requests. With a supervisor's permission, leaders may call in supplemental staff, i.e., RNs who are willing to work in the program part time. Leaders shuffle staff RNs from one team to another. Staff RNs, however, may make changes among themselves, providing they leave a message.

(2) Analysis

We agree with the RD that team leaders do not exercise independent judgment in assigning patients to RNs. It follows that the team leader assistants who substitute for team leaders also would not exercise independent judgment. Determining equitable patient loads and assigning patients based on the areas where the RNs already have patients are routine, clerical dispatching functions. The general testimony that leaders match patient needs to RN skills is unpersuasive. There is nothing in the record to indicate any differences in skills exercised by RNs. Rather, the RNs' ability to trade assignments on their own suggests equal skills. Calling in supplemental staff requires a supervisor's permission, so it does not involve independent judgment. Shuffling RNs from one team to another is a routine exercise of common sense and a clerical function similar to that of a dispatcher.

b. *Direction*

(1) Discussion

Team leaders inform staff RNs of what needs to be done. Staff RNs, however, outline what needs to be done for whoever is going to make the next visit. Team leaders train new staff RNs by working with the RN to show the RN the proper procedures and how to fill in the paperwork.

If a leader notices that an RN is rusty in regard to a particular procedure, the leader may suggest retraining, either with another RN team member or in outpatient therapy. In reporting poor performance of a staff RN, the leader does not give recommendations, but discusses the possibilities, and even those are not always followed. Team leaders do not have independent authority to discipline RNs but merely report information to the director. In addition, all RNs, including staff RNs, have an ethical obligation to report any noticed deficiencies of other RNs to the supervisor.

Leaders serve as the ''agent'' for observing RNs' clinical work and are consulted during evaluations. The supervisor sits down with the team leader to go through the evaluation form item by item. It is the supervisor, however, who prepares the evaluations. As

part of the peer review process, staff RNs also provide information about other RNs' performances. Team leaders have made hiring recommendations, but so have staff RNs.

(2) Analysis

We agree with the Regional Director that the leaders do not exercise independent judgment in the limited directions they give staff RNs. Informing RNs about what to do is merely a routine function of communicating to the RN what is in the patient's file and what the previous RN treating the patient has outlined.

The leaders' role in suggesting retraining regarding observed ''rusty'' skills and reporting poor performance is more in the nature of reporting problems than of recommending discipline, and even when the leader recommends a course of action, the recommendation is not always followed. This is merely a reportorial function common to that required by the professionalism of all RNs on the teams and does not involve the use of independent judgment in a leader's role as leader.

Team leaders may sit down with the supervisor when the supervisor prepares evaluations of team RNs. The supervisor, however, is responsible for the formal evaluation, and staff RNs also have input into the evaluations, particularly through peer reviews. Moreover, there is no evidence concerning the purpose or effect of the evaluations. In addition, there is no evidence that team leaders' hiring recommendations are any more effective than the hiring recommendations of staff RNs. Accordingly, we find that the leaders' role in directing staff RNs does not require the exercise of independent judgment.

c. *Conclusion*

In agreement with the Regional Director, we conclude that the home health team leaders and team leader assistants are not supervisors within the meaning of Section 2(11) of the Act. Accordingly, we find that they should be included in the unit and are eligible to vote in the election.

2. Home health care on-call leads

a. *Assignment*

(1) Discussion

The personal care and support unit in the home health department provides such general care as bathing, grooming, shopping, cooking, etc. for homebound patients. The two on-call leads rotate duties on a week-on, week-off basis to provide fill-in support for the supervisor. The leads are available by telephone or pager during the hours the main office is closed. The on-call leads make assignments of patients only when the assigned aide is absent. In the winter and flu season, this happens daily; at other times, nights go by when they make no assignments. The lead must match the patient with the aide in making an assignment, but they do so from a ''book'' listing about 20 skills possessed by the aides available for call-in duty and listing the patient's needs.

(2) Analysis

The on-call leads do not exercise independent judgment in assigning aides. There are only 10 or 15 aides available for call-in duty and the aides' skills are listed in the ''book,'' as are the clients' needs. Thus, the determination requires that the on-call lead merely go by the book to match an aide's skill to the patient's need. This is a routine, clerical dispatching function. Although there is testimony that the leads also attempt to match a patient's needs with an aide's personality, this is nothing more than the exercise of common sense and does not require supervisory independent judgment.

b. *Direction*

(1) Discussion

On-call leads field patients' complaints and discuss with aides such problems as what to do if they cannot enter the security door of a patient's apartment. If an aide refuses to make an assigned patient visit, the on-call lead reports the incident to the supervisor. The on-call lead may make a general recommendation on discipline but, because of the Employer's sliding scale of offenses and progressive disciplinary system, does not make a specific recommendation. The on-call leads also regularly provide the supervisor with information regarding aides' performances. Although there is evidence that this information is used by the supervisor in making aides' evaluations, there is no evidence as to the effect of such evaluations.

(2) Analysis

We agree with the Regional Director that the on-call leads' direction of aides does not involve the exercise of independent judgment. Dealing with patient complaints does not per se involve direction of aides. ''Walking'' aides through such common problems as how to deal with the inability to enter an apartment building's locked security door requires only the exercise of routine judgment. Reporting refusals to carry out assignments involves only clerical, reportorial judgment. Any input into evaluations involves only a similar reportorial function, and it is the supervisor who makes the final evaluation.

c. *Conclusion*

In agreement with the Regional Director, we conclude that the on-call leads are not supervisors within the meaning of Section 2(11) of the Act. Accordingly,

we find that they should be included in the unit and are eligible to vote in the election.

3. Employee health staff nurse

a. *Discussion*

The employee health staff nurse works in the employee on-the-job recovery program by which employees on workers' compensation are gradually worked back into the system. The program monitors various aspects of workers' compensation, the Americans with Disabilities Act, counseling employees in the program, and compliance with universal precautions, as well as running the job recovery program. The employee health specialist, who was stipulated as excluded from the unit, oversees the program. The employee health staff nurse performs those duties when the specialist is away from work during vacations, for meetings, for illness, etc. This happens a few times a month.

b. *Analysis*

It is well established that an employee who substitutes for a supervisor may be deemed a supervisor only if that individual's exercise of supervisory authority is both regular and substantial. *Hexacomb Corp*., 313 NLRB 983, 984 (1994). Here, however, there is no evidence that the employee health staff nurse actually exercises any statutory authority when substituting for the specialist. Moreover, since the health nurse substitutes only when the specialist is sick, on vacation, or at meetings, such substitution is sporadic or irregular, and therefore insufficient to establish supervisory authority. Id.

There is also no record evidence, with limited exception, concerning what authority or duties the employee health staff nurse exercises on her own. The exception is that the health staff nurse determines the rates of pay for the interim jobs of the program participants with whom she directly works. The record shows, however, that determining the rates of pay is done pursuant to the application of a formula and that the personnel department is also involved in calculating the pay. Because the record fails to show that the employee health staff nurse engages in any significant assignment or direction of employees, we find that the record fails to establish that the employee health staff nurse is a supervisor.

c. *Conclusion*

We conclude that the employee health staff nurse is not a supervisor within the meaning of Section 2(11) of the Act. Accordingly, we find that she should be included in the unit and is eligible to vote in the election.

4. Lead: neuro outpatient rehabilitation center

a. *Assignment*

(1) Discussion

This center serves patients who require rehabilitative therapy beyond the inpatient stay, including physical, occupational, and speech therapy. The one certified RN provides any needed RN care and serves as the lead employee for the unit. The lead assigns patients to particular therapists, taking into account the therapists' skills and availability. The example given, however, is that, if a patient needs disabled driver's education, the lead looks for a therapist with the ability to perform that function. The lead also coordinates loans of therapists within different departments of the Hospital and loans within the pool of the Hospital and other physical care providers. The lead has authority to ask for loaners back but informs the assistant director. If the staff is not busy, the lead will communicate that fact to other Hospital departments. The lead may, with the supervisor's permission, tell therapists that their work is not needed and that they may go home.

(2) Analysis

The leads' assignment of employees does not require the use of independent judgment. Assigning patients on the basis of availability of a therapist and on whether the therapist is able to provide rehabilitative driver's education is a routine, clerical dispatching function. The lead's coordination of the loaner programs involves only the routine decision of whether the staff therapists are busy or available. The lead has no independent discretion to send an employee home early. Accordingly, we find that the lead does not exercise independent judgment in assigning employees.

b. *Direction*

(1) Discussion

The lead is responsible for writing policy and quality improvement plans, for some case management, for utilization review, and for communication with insurance companies. The lead also helps prepare written evaluations of employees. On occasion, she may make recommendations that a therapist needs education.

(2) Analysis

We find that the lead does not exercise independent judgment in directing employees. There is no evidence that the lead's role in such functions as exercising responsibility for writing certain plans and communicating with insurance companies involves direction of employees. The lead does not independently prepare evaluations, and there is no evidence showing what use is made of the evaluations. Similarly, there is no evidence of how often a lead makes recommendations re-

garding therapists' need for education or whether the recommendations are followed. Such recommendations are therefore at most reportorial.

c. *Conclusion*

We conclude that the lead RN in the neuro outpatient rehabilitation center is not a supervisor within the meaning of Section 2(11) of the Act. Accordingly, we find that she should be included in the unit and is eligible to vote in the election.

VII. CONCLUSION

We have concluded that the disputed employees are not statutory supervisors as contended by the Employer. Accordingly, we shall remand this proceeding to the Regional Director to take further appropriate action.

ORDER

The National Labor Relations Board orders that this proceeding be remanded to the Regional Director to open and count the ballots of all eligible voters, to prepare a tally of ballots, and to issue the appropriate certification or to take other appropriate action in accord with this Decision and Order.

MEMBER COHEN, dissenting.

Section 2(11) of the Act sets forth the definitions of the term ''supervisor.'' In brief, the section lists certain actions. If a person has the authority to take one or more of these actions, or the authority to effectively recommend such an action, the person is a supervisor, provided that the person uses independent judgment in taking or recommending the action.

Two of the listed actions are (1) assigning employees and (2) responsibly directing employees. My colleagues go to some lengths to say that the persons in this case, who have authority to take these actions, do not use independent judgment in doing so. I disagree. My reasons are set forth below.

Before beginning my analysis, it is instructive to reflect upon the legal context in which this issue arises. In *NLRB v. Health Care & Retirement Corp*., 114 S.Ct. 1778 (1994), the Board contended that certain charge nurses were not supervisors. The Board did not challenge the proposition that the nurses exercised powers under Section 2(11), and the Board did not argue that the nurses lacked independent judgment in this regard. Rather, the Board maintained that the exercise of the power was in the interest of the patient, and not in the interest of the employer.

The Supreme Court rejected the argument. As the Court pointed out, ''patient care is the business of a nursing home and it follows that attending to the needs of the nursing home patients, who are the employer's customers, is in the interest of the employer.''

Thus, the Board was unsuccessful in its effort to manipulate the phrase ''in the interest of the employer.'' My colleagues, undaunted, now seek to achieve the same result through a misinterpretation of the phrase ''independent judgment.'' The effort is no more successful.

My colleagues contend that a person who directs an employee is not a supervisor if the directing person acts on the basis of superior training, experience, and skills. In their view, such direction is that of a leadperson or straw boss, not that of a genuine supervisor.

The legislative history is directly contrary to the position of my colleagues. The proposition that a leadperson or a straw boss is not a supervisor comes from Senate Report No. 105.[1] However, *after* that Senate Report, Senator Flanders proposed additional language to the bill. The additional language was the phrase ''responsibly to direct.'' Senator Flanders, at that later time, said that persons with the authority to responsibly direct ''are above the grade of straw bosses, lead men, set-up men and other minor supervisory employees as enumerated in the [Senate] report.'' Senator Flanders' proposal was adopted. Thus, a person who responsibly directs others is not a mere leadperson or straw boss. Rather, that person is a supervisor.

There remains, of course, the question of what ''responsible direction'' means. My colleagues say that a person is not a supervisor if his or her directives are based on superior training, experience, and skills.

Once again, Senator Flanders provides the refutation.[2] Senator Flanders described the director-supervisor as one who acts on the basis of ''personal experience, training and ability.'' Thus, my colleagues' position is directly contrary to the position of Senator Flanders, the author of the relevant provision.[3]

My colleagues also suggest that there is some tension between the Section 2(11) exclusion of ''supervisors'' from the protection of the Act, and the Section 2(12) inclusion of ''professionals'' as protected by the Act. They recognize, of course, the familiar rule that each and every section of the Act is to be given effect, and the corollary rule that the Act is to be construed so as to avoid conflicts between sections thereof. Applying these principles, this alleged tension between Section 2(11) and (12) is easily avoided. Concededly, the phrase ''independent judgment'' in Section 2(11)

[1] S. Rep. No. 105, 80th Cong., 1st Sess., 4 (1947).

[2] My colleagues say that Senator Flanders was speaking of ''responsible direction,'' rather than ''direction.'' In my view, however, his statement, in context, embraced both words.

[3] *Southern Bleachery*, cited by my colleagues, is not to the contrary. It does not focus upon the phrase ''responsible direction.'' It merely holds that the attempt there to elevate employees to supervisory status was not effective, i.e., it did not in fact change their duties.

of the Act is roughly mirrored by the phrase ''discretion and judgment'' in Section 2(12) of the Act. But, the difference between the two is substantial and real. The supervisor exercises independent judgment with respect to the functions listed in Section 2(11), and he or she does so vis-a-vis employees. By contrast, the professional exercises discretion and judgment with respect to the task that he or she performs.

Thus, for example, the task of devising a patient treatment plan involves the use of professional judgment. The nurse who devises that plan is a professional employee. But, the nurse who then administers that plan may have to exercise supervisory responsibilities vis-a-vis employees. For example, the nurse must decide which of the various tasks (outlined in the plan) must be done first, and the nurse must then select someone to perform that task. In the words of Senator Flanders, the nurse must decide ''what job will be undertaken next and who shall do it.''[4] In addition, the nurse must take steps to assure that the task is performed correctly. In the words of Senator Flanders, the nurse gives ''instructions for its proper performance, and training in the performance of unfamiliar tasks.''[5]

My colleagues assert that a charge nurse exercises only a routine function when she assigns an employee to a patient or to a wing. I disagree. As my colleagues concede, such an assignment is based on an assessment of the employee's skills. That evaluation is largely a matter of subjective judgment. For example, the judgment that employee A works particularly well with elderly patients, or that employee B works particularly well with coronary patients, is not a judgment based upon adding up points on a numerical scale. Rather, the judgment is one of discretion, requiring the use of independent analysis and decision-making.[6]

Finally, I note that, in Sec. 8(a)(1) cases, the Board has found supervisory status with respect to individuals who have authority comparable to that of the charge nurses involved here.[7] In my view, the Board should apply the same standard in unfair labor practice cases (where the General Counsel and union seek to establish supervisory status) as in representation cases (where the union often seeks to establish the contrary). In addition, I note that the Board, in 8(a)(1) cases, has found supervisory status with respect to nurses who have authority comparable to the charge nurses involved herein.[8] Although these cases were overruled in *Northcrest Nursing Home*,[9] the overruling was based on the now-discredited ''patient care'' analysis.

In sum, in an effort to transform charge nurses into employees, my colleagues have ignored the substantial degree of independent judgment which charge nurses possess. Charge nurses are not automatons who carry out their functions by rote. The essence of their job is judgment.[10] My colleagues have also ignored the legislative history which, often in haec verba, describes the function that charge nurses perform, and makes clear that those functions are supervisory.

The Instant Case

1. Using the above analysis, it is clear that the charge nurses in this case are supervisors. In this regard, I note the following:

a. Charge nurses assign employees to patients. Although other nurses provide information regarding patients, it is the charge nurse who must assimilate this information with the charge nurse's assessment of employee skills and to then make an independent judgement as to which employee to assign to which task.

b. Charge nurses select replacements for absent RNs. This will involve locating a replacement elsewhere in the hospital, or calling an RN into work. In the latter situation, the charge nurse can authorize overtime.

c. Charge nurses select RNs for duty if there is a staff-shortage because of high patient load. Although the charge nurse cannot order an off-duty employee to come to work, the offering of employment and overtime is itself a supervisory function.[11]

d. Charge nurses determine staffing needs for the next shift. They can ask RNs to stay over or to report early.

e. Charge nurses approve or disapprove break periods. That decision is based on their independent judgment of the workload of the entire unit.

f. Charge nurses monitor the performance of employees. They intervene in serious cases of poor performance and make a report and recommendation in less serious ones.

[4] Legislative History of the Labor Management Relations Act of 1947, 1303.

[5] Id.

[6] I agree with my colleagues that all RNs exercise judgment. My essential point is that the charge nurses involved herein exercise independent judgment vis-a-vis the assignment and direction of employees.

[7] See, e.g., *Clark & Wilkins Industries*, 290 NLRB 106 (1988); *Great American Products*, 312 NLRB 962 (1993).

[8] *Avon Convalescent Center*, 200 NLRB 702 (1972), enf. granted 490 F.2d 1384 (6th Cir. 1974); *Rockville Nursing Center*, 193 NLRB 959 (1971).

[9] 313 NLRB 491 (1993).

[10] *Beverly California Corp. v. NLRB*, 970 F.2d 1548, 1553 (6th Cir. 1992), denying enf. 303 NLRB No. 20 (May 28, 1991) (not reported in Board volumes).

[11] See, e.g., *Harbert International Services*, 299 NLRB 472, 478 (1990); *Cannon Industries*, 291 NLRB 632, 635–636 (1988); *NLRB v. River Hills Nursing Home West*, 705 F.2d 1472 (7th Cir. 1983), denying enf. 262 NLRB 1458 (1982); *ITT Corp. v. NLRB*, 712 F.2d 40 (2d Cir. 1983), denying enf. 265 NLRB 1480 (1982).

2. I also find that the team leaders are supervisors based on the following:[12]

a. Team leaders assign RNs to patients based, inter alia, upon their assessment of employee skills and patient needs.

b. Team leaders decide who is to be called in as supplemental staff.

c. Team leaders reassign RNs from one team to another.

d. Team leaders provide input into the evaluation of RNs. The fact that others also do so is irrelevant.[13]

e. Team leaders make recommendations concerning hire. The fact that others do so is irrelevant.[14]

f. Team leaders recommend retraining for RNs with ''rusty'' skills.

3. Further, I find that the home health care on-call leads are supervisors based on the following:

a. On-call leads assign aides to patients, when the regularly scheduled aide is absent or delayed, by matching the needs of the patient with the qualifications of the available aides.

b. On-call leads participate in the evaluations of aides.

c. On-call leads effectively recommend discipline of aides.

---

[12] I note that team leader assistants occasionally fill in for team leaders. However, the extent to which they do so is not known. Accordingly, I would allow them to vote subject to challenge.

[13] See, e.g., *Atlanta Newspapers*, 306 NLRB 751, 756 (1992) (supervisory men-in-charge and foremen participate in evaluation of assistants).

Inasmuch as the Employer asserts supervisory status, and inasmuch as the Board's responsibility is to determine this issue, I believe that all evidence relative thereto should be considered.

[14] See, e.g., *Delta Carbonate, Inc.*, 307 NLRB 118, 119–120 (1992).